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The Bioethics of Active Ageing in the UN Decade

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Abstract. Population ageing is increasingly framed as a fiscal and administrative burden, yet the UN Decade of Healthy Ageing sets a different normative horizon: healthy ageing aligned with the final decade of the Sustainable Development Goals. This article offers a conceptual and bioethical analysis of why "active ageing" can become rhetorically attractive while remaining materially unattainable for many older persons. It distinguishes two governance regimes: passive-assisted ageing, organised around downstream risk containment, scarcity triage, and administrative burden; and active ageing reconstructed as dignified longevity, assessed by functional ability and its social preconditions. The analysis introduces the "malaise state" to name structural welfare drift under demographic pressure and political–economic incentives, and develops the epistemic–existential paradox: societies can be knowledge-rich yet equity-poor because scientific and digital proliferation does not translate into health without upstream action on social and commercial determinants. Extending the argument globally, the paper contrasts longevity with inequality in high-income settings and premature mortality in low-income contexts, arguing that the Decade must be treated as a justice project rather than a behavioural exhortation. It concludes with a Decade-alignment checklist and policy-relevant ethical commitments.

Keywords: healthy aging; health equity; social determinants of health; ageism; digital divide; health policy.

1 Introduction

Population ageing is frequently narrated as an administrative challenge: how to fund pensions, sustain health services, and deliver long-term care in societies where the old-age dependency ratio is rising. That framing is not false, but it is ethically incomplete. It risks reducing later life to a budget line and older persons to system "users", while obscuring the normative question that should anchor any ageing policy: what does it mean to age with dignity, and under what conditions can societies reasonably claim to be enabling it? The United Nations Decade of Healthy Ageing (2021–2030), led by the World Health Organization (WHO), was launched precisely because the answer cannot be left to demographic arithmetic alone; it requires coordinated ethical, political, and

institutional choices about inclusion, care, environments, and equity, explicitly aligned with the final decade of the Sustainable Development Goals (World Health Organization 2025a; World Health Organization 2022; Keating et al. 2022).

This paper argues that the central bioethical fault-line is not simply between "more" versus "less" welfare, nor between "medical" versus "social" models of ageing. Rather, it lies between two regimes of governance: passive-assisted ageing and active ageing oriented to dignified longevity. The former treats ageing primarily as a downstream problem to be managed after functional decline has already occurred, typically through an assistential architecture centred on service delivery, risk containment, and institutional triage. The latter treats ageing as a life-course process whose ethical aim is not mere survival but the maintenance of the real freedoms that make later life worth living. In WHO's formulation, *healthy ageing* is "the process of developing and maintaining the functional ability that enables well-being in older age" (World Health Organization 2025a).

Framed this way, "active ageing" is not a moral demand for perpetual self-optimisation, nor a euphemism for shifting responsibility onto individuals. It is a normative claim about justice: societies are ethically obligated to organise environments, care systems, and social protections so that people can sustain functional ability and relational life as they age, with special attention to those whose lives have been structured by disadvantage. The empirical and conceptual uptake of WHO's functional-ability framework in recent gerontology and public-health scholarship further underscores that this is not rhetorical branding, but an operationalisable orientation for policy design and evaluation (World Health Organization 2025a).

The problem is that contemporary welfare arrangements in many contexts are drifting into what we call a malaise state (Torfs et al. 2021). By "malaise state" we do not mean a cultural mood, an individual psychological condition, or a nostalgic lament for a lost social contract. We mean a structural syndrome in which the public promise of welfare increasingly converts into routinised exposure to insecurity, waiting, administrative opacity, and risk transfer from institutions to individuals and families. In such a configuration, the governance of ageing becomes less about enabling functional ability and more about managing chronic scarcity and liability, even as ageing-related fiscal pressures on pensions, health, and long-term care become a dominant political horizon across OECD settings (Koutsogeorgopoulou & Morgavi 2025).

This syndrome does not arise in a vacuum. It is intensified by the contemporary technoscientific condition: accelerating biomedical innovation, digital health systems, and platform-mediated infrastructures that expand the availability of knowledge and tools but also expand the institutional and commercial interfaces through which health is governed. The malaise state is therefore not simply "less welfare"; it is a reconfiguration of welfare under conditions of complexity and marketisation, often resulting in a paradoxical mixture of hyper-knowledge and diminished well-being. WHO's most recent synthesis on ageing and health emphasises how health in older age is shaped not only by diseases but by lifelong, cumulative interactions between intrinsic capacity, environments, and inequality (World Health Organization 2025a).

This brings us to the paper's second core concept: the epistemic–existential paradox. The paradox can be stated plainly: *the proliferation of knowledge does not automatically translate into global well-being or global health*. The modern imagination often treats scientific growth as a proxy for moral progress. Yet, in practice, the pipeline from knowledge to well-being is mediated by institutional design, political economy, and the social distribution of resources, power, and trust. WHO's World report on social determinants of health equity (World Health Organization 2025b) sharpens this point: avoidable and unjust health gaps are driven by non-medical root causes and can shorten lives by decades, meaning that biomedical advances alone are structurally incapable of delivering equity without upstream action (World Health Organization 2025b).

Within ageing policy, the paradox manifests as follows. Societies may invest heavily in biomedical research, digital health, and clinical innovation while simultaneously tolerating care infrastructures that are fragmented, inequitable, and oriented toward late-stage management rather than capability preservation. In such contexts, older persons often encounter a double bind: empowerment rhetoric proliferates, yet lived experience is shaped by institutional delays, gatekeeping, and socio-economic barriers that restrict real agency. The paradox is therefore not merely epistemic (a matter of what is known), but existential (a matter of how life is actually lived under prevailing institutional conditions).

A crucial mechanism in this translation failure is captured by the notion of the commercial determinants of health: the conditions, actions, and omissions by commercial actors that affect health within wider political-economic systems. WHO/Europe's 2024 regional synthesis on commercial determinants of noncommunicable diseases illustrates the scale of this problem in concrete terms, linking specific industries, practices, and regulatory environments to population-level morbidity and mortality (World Health Organization Regional Office for Europe 2024). This concept offers a bioethically disciplined way to criticise capitalism without collapsing into slogan or caricature. The point is not that commerce is intrinsically unethical, but that predictable incentive structures can generate systematic misalignment between profit-maximising strategies and equity-enhancing health outcomes. In ageing societies, that misalignment can manifest as commodified care, stratified access to preventive resources, and a longevity landscape where the burdens of morbidity and dependency fall disproportionately on those already disadvantaged.

The global dimension of the argument is non-negotiable. The world is ageing, but it is also ageing unequally, and in many settings it is still dying early. UN demographic syntheses continue to document divergent regional age structures and trajectories, with updated projections and uncertainty ranges that underscore how rapidly the age composition of societies is changing (United Nations, Department of Economic and Social Affairs, Population Division 2024; United Nations, Department of Economic and Social Affairs, Population Division 2023). Meanwhile, World Bank indicators show that life expectancy at birth in low-income countries was 65 years in 2023 (World Bank 2023). Any bioethics of active ageing that ignores this divergence risks becoming parochial: a discourse of "healthy ageing" for the privileged, rather than a justice-oriented account of human flourishing across unequal social worlds.

The paper develops three claims. First, the *malaise state* is a useful bioethical diagnostic category for understanding why passive-assisted ageing becomes the default regime: it names a structural drift in welfare governance whereby protective institutions increasingly function as scarcity managers, producing predictable harms to dignity, agency, and capability. Second, the *epistemic–existential paradox* explains why knowledge-rich societies can remain well-being-poor: scientific proliferation does not deliver health equity unless knowledge is translated into enabling environments, equitable access, and trustworthy care infrastructures, as foregrounded by WHO's 2025 equity agenda (World Health Organization 2025b). Third, *active ageing* should be reconstructed as dignified longevity under conditions of health equity, consistent with WHO's functional-ability definition, and evaluated against the Decade's ethical commitments rather than against productivity-centred or austerity-centred benchmarks (World Health Organization 2025a; World Health Organization 2022).

The remainder of the article proceeds as follows. Section 2 specifies the conceptual framework (passive-assisted ageing, dignified longevity, malaise state, and the epistemic–existential paradox) and clarifies the normative yardstick supplied by the UN Decade of Healthy Ageing and WHO's functional-ability approach. Section 3 maps the institutional and political-economic mechanisms that produce translation failure, with particular attention to health equity and the commercial determinants of health. Section 4 develops the global justice implications of ageing "at two speeds" and draws out policy-relevant ethical commitments for the Decade.

2. Conceptual Framework and Definitions

2.1. Healthy ageing as the normative yardstick: from "active ageing" to functional ability

The evaluative standard of this paper is not "successful ageing" as an individual achievement, nor "active ageing" as a productivity norm. It is healthy ageing, understood in WHO's sense as "the process of developing and maintaining the functional ability that enables well-being in older age" (World Health Organization 2020). This definition is ethically consequential because it shifts the unit of analysis from diseases and services to capabilities: what persons can actually be and do, in context, across the life course.

WHO further specifies functional ability in capability-like terms: the health-related attributes that enable people to meet basic needs, learn and decide, be mobile, sustain relationships, and contribute (World Health Organization 2020; Rudnicka et al. 2020). This language resonates with the capability approach in moral and political philosophy, where justice concerns the real freedoms people have to lead lives they have reason to value, rather than the mere provision of resources or the formal availability of choices (Sen 1999; Nussbaum 2011; Venkatapuram and Thiyagarajan 2023). The capability framing matters here because it clarifies why "active ageing" cannot be reduced to lifestyle advice: functional ability is co-produced by intrinsic capacity (physical and mental capacities) and by environments (social, economic, built, institutional).

The UN Decade of Healthy Ageing (2021–2030) institutionalises this normative yardstick by treating healthy ageing as a multi-sector project rather than as a clinical

afterthought, and by explicitly connecting the agenda to the SDG horizon of "leaving no one behind" (World Health Organization 2022; World Health Organization 2025a; Cesari et al. 2022). In the terms of this paper, "active ageing" is therefore acceptable only insofar as it tracks this functional-ability standard and its equity commitments (World Health Organization 2002). When "active ageing" is used to mean self-optimisation, market consumption, or moralised resilience under austerity, it becomes conceptually and ethically incoherent with the Decade's framework.

2.2. Passive-assisted ageing: a downstream governance regime

Passive-assisted ageing designates a regime in which ageing is governed primarily as a downstream problem to be managed after decline has occurred. It is "passive" not because older persons lack agency by nature, but because institutions are designed around compensatory assistance rather than around capability preservation and enabling environments. It is "assisted" insofar as the dominant response is service delivery, often fragmented across sectors and organised around risk containment, compliance, and throughput.

Four institutional signatures typically co-occur:

1. Downstream bias: policy effort concentrates on late-stage management (acute episodes, dependency, institutional placement) rather than on upstream determinants of capacity, prevention, and environment design.
2. Triage rationality under scarcity: decisions are increasingly shaped by waiting lists, eligibility thresholds, and liability minimisation rather than by continuity and capability trajectories, especially under ageing-related fiscal pressures (Koutsogeorgopoulou & Morgavi 2025; Maboloc & Cutillas 2025).
3. Fragmentation of care: older persons experience discontinuity across primary care, specialist care, social care, and community supports, undermining the integrative conditions that the Decade identifies as essential to healthy ageing (World Health Organization 2025a).
4. Epistemic asymmetry: knowledge is operationally concentrated in professionals and systems, while older persons are positioned as objects of assessment rather than as interpreters of their own functional trajectories. This produces a form of dependence that is simultaneously practical and epistemic.

The key point is that passive-assisted ageing is not merely an unfortunate outcome of demography. It is a design choice embedded in welfare institutions when they are configured as scarcity managers. As populations age unevenly across regions, the incentive to default to downstream management intensifies (United Nations, Department of Economic and Social Affairs, Population Division 2024). The concept is therefore descriptive and diagnostic: it names a regime that can be criticised on capability and equity grounds, without implying that assistance as such is unethical. Assistance becomes ethically problematic when it substitutes for, rather than supports, the preservation of functional ability and dignified autonomy.

2.3. The "malaise state": a structural syndrome of welfare drift

The malaise state is a diagnostic category for a particular kind of welfare-state drift. It does not mean "less welfare" in a purely quantitative sense. It refers to a structural syndrome in which institutions retain the protective rhetoric of welfare while increasingly operating as infrastructures of insecurity, waiting, and risk transfer. In this configuration, citizens encounter welfare not as an enabling platform for flourishing, but as a procedural maze in which time, attention, and trust are consumed by administrative friction.

Operationally, the malaise state can be characterised by five features:

1. Chronic scarcity governance: services are organised around rationing, eligibility policing, and liability control. Ageing-related fiscal pressures become a permanent political horizon, normalising triage as a default rather than an emergency mode (Koutsogeorgopoulou & Morgavi 2025).
2. Administrative opacity and delay: access to care and support is mediated by layers of procedure that generate predictable harms to those with lower resources, lower health literacy, or lower institutional fluency.
3. Risk transfer to individuals and families: care burdens, navigation burdens, and the moral responsibility for outcomes are shifted outward, often without corresponding increases in capacity or support.
4. Stratified access: territorial and socio-economic gradients widen, so that the same formal entitlement yields different practical capability sets.
5. Responsibilisation without enabling conditions: individuals are urged to age "actively" while the structural determinants of functional ability (housing, income security, safe environments, social connection, accessible care) remain unevenly distributed.

This syndrome is particularly visible in ageing governance because later life concentrates cumulative disadvantage and because functional decline interacts strongly with institutional friction. The malaise state is thus the macro-context in which passive-assisted ageing becomes the default regime: not through a single policy failure, but through a systemic conversion of welfare into scarcity management.

2.4. The epistemic–existential paradox as a translation failure

The epistemic–existential paradox is the central explanatory construct of the article. It formalises the claim that knowledge proliferation does not reliably translate into well-being, especially under conditions of inequality. The paradox can be represented as a translation chain:

- Input: expanding biomedical knowledge, data infrastructures, technological capabilities.
- Mediators: institutional design, political economy, social and commercial determinants, distribution of power and trust.
- Output: uneven functional ability and uneven well-being, including situations where knowledge-rich contexts remain equity-poor.

This is not an anti-science claim. It is a bioethical claim about conversion conditions. WHO's World report on social determinants of health equity (World Health Organization 2025b) supports the idea that avoidable health gaps are driven by upstream, non-medical causes and can shorten lives by decades, implying that biomedical progress alone cannot deliver equity without structural translation (World Health Organization 2025b). In capability terms: knowledge is a resource, but it becomes ethically meaningful only when it is converted into functionings and freedoms for those who are otherwise constrained.

Two translation bottlenecks are especially relevant for ageing:

1. Social determinants bottleneck: the conditions in which people live and age shape intrinsic capacity trajectories and access to enabling environments, directly affecting functional ability. When these determinants are unequal, healthy ageing becomes stratified regardless of scientific progress (World Health Organization 2025b).
2. Commercial determinants bottleneck: incentive structures and commercial strategies can systematically bias the knowledge-to-well-being pipeline toward profitable pathways rather than equitable pathways. WHO/Europe's 2024 synthesis on commercial determinants of noncommunicable diseases documents how corporate practices and regulatory environments can drive population-level morbidity and mortality (World Health Organization Regional Office for Europe 2024).

The paradox is "existential" because it is lived as a contradiction: older persons are addressed by empowerment rhetoric and surrounded by the outputs of technoscience, yet their concrete capability set is restricted by institutional delay, fragmented care, and unequal environments. The paradox is therefore a conceptual bridge between micro-level experience (dependency, loss of agency) and macro-level structure (malaise state, determinants of health, political economy).

A practical implication follows: when "active ageing" policies are designed as information campaigns or individual behaviour interventions in the absence of enabling conditions, they risk becoming instruments of responsibilisation. In the present framework, that is a category mistake. Active ageing is ethically defensible only as capability-enabling governance under equity constraints.

2.5. Scope conditions, analytic strategy, and limits

This article is conceptual and normative: it offers a diagnostic framework and a bioethical argument rather than an empirical evaluation of specific national systems. Its claims are designed to be policy-relevant and testable in principle, by connecting normative standards (functional ability, equity) to identifiable institutional mechanisms (scarcity governance, risk transfer, determinants bottlenecks).

Three scope conditions delimit what is and is not being claimed:

1. Not a rejection of assistance or long-term care: assistance is ethically required where functional decline occurs. The critique targets a governance regime that

treats downstream assistance as a substitute for capability preservation and enabling environments (World Health Organization 2025a).
2. Not a nostalgic defence of the welfare state as it was: the malaise-state concept names a transformation in welfare governance under conditions of demographic change and fiscal pressure, not a simple story of moral decline (Koutsogeorgopoulou & Morgavi 2025).
3. Not a moralisation of individual behaviour: "active ageing" is reconstructed as a collective obligation to expand functional ability and reduce inequity, consistent with the Decade's SDG-aligned commitments (World Health Organization 2022; World Health Organization 2025a).

Finally, to keep the framework operational rather than merely rhetorical, we will use the following diagnostic test throughout the argument: a policy, institution, or governance model counts as aligned with healthy ageing only insofar as it plausibly increases functional ability and well-being under conditions of equity, especially for those structurally disadvantaged. Where the knowledge-to-well-being translation fails, the explanatory burden shifts from individual choice to the mediating institutions and determinants that structure real life chances.

3. Mechanisms of Translation Failure: Why Knowledge-Rich Societies Become Equity-Poor Ageing Societies

3.1. From welfare to malaise: institutional drift under demographic and fiscal pressure

The transition from a welfare-state imaginary to a *malaise state* is rarely announced as a normative shift. It is more often enacted as a sequence of technical adjustments: budget caps, eligibility reforms, outsourcing, digitalisation, performance indicators, "efficiency" programmes, and managerial reorganisation. Over time, however, these adjustments can reconfigure the moral architecture of welfare. What begins as a promise to enable human flourishing under conditions of vulnerability can become a system primarily designed to manage scarcity, liability, and political risk. In ageing governance, this drift is especially visible because later life concentrates cumulative disadvantage and because long-term care and chronic illness amplify the consequences of administrative friction.

Ageing-related fiscal pressure is not a rhetorical device; it is a documented policy horizon across OECD contexts (Broadbent et al. 2024; McCartney et al. 2022). Yet the ethical question is how such pressure is operationalised. If it is translated into rationing, delayed access, and narrowed entitlements, the system tends to default toward downstream, compensatory responses. If it is translated into enabling environments, prevention, and continuity, the system can preserve functional ability longer and distribute dependency burdens more fairly. The *malaise state* names the former pathway: a mode of welfare governance in which scarcity management becomes routinised and, crucially, normalised (Koutsogeorgopoulou & Morgavi 2025).

This drift yields predictable structural effects.

First, it produces a downstream bias. When political attention is fixed on acute costs and short-term budget cycles, investment shifts away from upstream determinants of

functional ability (housing, walkable environments, social connection, prevention, primary care continuity) and toward late-stage interventions. This is ethically significant because the WHO functional-ability framework treats healthy ageing as a trajectory shaped by cumulative interactions between intrinsic capacity and environments, not as an abrupt clinical event (World Health Organization 2020). A downstream bias therefore structurally undermines the very standard that the UN Decade of Healthy Ageing is intended to promote.

Second, it intensifies administrative load. As systems attempt to ration under pressure, they multiply procedural gates: assessments, forms, re-assessments, referrals, authorisations, and eligibility checks. The effect is not neutral (Health Affairs 2020). Administrative load is a distributive phenomenon (Herd and Moynihan 2018). It burdens those with less time, fewer resources, lower institutional literacy, and lower digital access. In ageing policy, this often means that the people most in need of enabling conditions face the highest navigation costs, thereby converting entitlement into a lottery of institutional fluency (Barford and Gray 2022).

Third, the drift produces risk transfer. When services are limited or fragmented, the burden of care shifts to families and informal networks. That transfer is routinely gendered, unequal, and often invisible in policy accounting. Ethically, the central problem is not that families care, but that the system silently relies on unpaid care as a substitute for justice-oriented infrastructure. The result is a redistribution of vulnerability rather than its mitigation.

Fourth, the drift generates institutional triage as a default. Triage is ethically defensible in emergencies; it becomes ethically corrosive when it becomes routine (Mikton et al. 2021; Rueda 2021). In a malaise-state configuration, waiting and rationing are not temporary "stress responses" but stable properties of the system. This pushes ageing governance toward passive-assisted ageing: older persons are "processed" as cases in a scarcity pipeline rather than supported as agents navigating functional trajectories.

A reasonable counterargument is that scarcity is real, and that systems must set priorities. This is correct. But it does not resolve the bioethical question. Priority-setting is not the same as scarcity governance. Scarcity governance becomes ethically questionable when it systematically converts structural constraints into individual burdens, and when it uses empowerment rhetoric to legitimise that conversion. The critical move, therefore, is not to deny constraints, but to show how constraints are translated into institutional designs that either enable or disable healthy ageing.

3.2. The social determinants bottleneck: why functional ability is structurally stratified

The functional-ability standard makes a decisive claim: well-being in older age is not reducible to clinical metrics or healthcare utilisation. It depends on the environment and on the distribution of resources, opportunities, and protection across the life course (World Health Organization 2020). This implies a direct bioethical consequence: *active* or *healthy* ageing is not primarily a matter of individual merit. It is a matter of capability formation under unequal conditions.

The WHO World report on social determinants of health equity (World Health Organization 2025b) provides a contemporary synthesis of this point, arguing that avoidable and unjust health gaps are driven by upstream causes and can shorten lives by

decades (World Health Organization 2025b). In the present argument, these determinants function as a translation bottleneck: they mediate whether knowledge, technologies, and healthcare capacity are converted into functional ability and well-being.

To see the bottleneck, consider three domains that are especially relevant to ageing.

(1) Built and social environments. Walkable neighbourhoods, safe public space, accessible transport, and age-friendly housing are not optional "quality of life" add-ons. They are capability infrastructures. They determine whether older persons can remain mobile, socially connected, and independent in daily functioning. In a malaise-state drift, such environments are often treated as secondary to acute healthcare spending, despite their upstream role in preserving functional ability.

(2) Income security and labour trajectories. Ageing is the endpoint of decades-long exposure to labour conditions, unemployment cycles, precarious work, and unequal access to protection. Functional ability in later life, therefore, is partly a historical record of political economy. When "active ageing" is framed as individual responsibility without attention to these trajectories, it becomes an ethical misattribution: structural harm is reinterpreted as personal failure.

(3) Education and health literacy. The epistemic dimensions of ageing are not peripheral. In complex systems, the ability to understand health information, navigate services, and make informed decisions becomes a crucial component of autonomy. Yet health literacy is socially stratified. If systems rely on informed self-management while simultaneously generating administrative complexity, they widen capability gaps: those with resources gain agency, while those without them experience intensified dependence.

These domains show why the social determinants bottleneck is not only empirical but normative. It undermines the moral legitimacy of "active ageing" narratives when enabling conditions are absent. It also clarifies why the epistemic–existential paradox is predictable: societies can become knowledge-rich and yet equity-poor if knowledge is not translated into shared capability infrastructures.

A second counterargument is that healthcare systems alone cannot solve these determinants. Again, correct. But it strengthens rather than weakens the Decade's logic: healthy ageing requires cross-sectoral governance precisely because functional ability is co-produced by environments and institutions beyond healthcare (World Health Organization 2022). The problem is not that healthcare fails to deliver equity single-handedly; the problem is that governance structures often treat cross-sector action as aspirational while continuing to operate downstream systems that institutionalise dependency.

3.3. The commercial determinants bottleneck: incentives that bias the knowledge-to-well-being pipeline

The social determinants bottleneck explains why resources and environments stratify functional ability. The commercial determinants bottleneck explains why knowledge, technologies, and services can be systematically directed away from equity-enhancing pathways. WHO/Europe's 2024 synthesis offers a clear articulation: commercial actors shape population health through conditions, practices, and regulatory environments that influence consumption, exposure, and policy (World Health Organization Regional Of-

fice for Europe 2024). Commercial determinants are not a conspiracy; they are an incentive structure operating through market logics, lobbying, advertising, supply chains, and the design of consumer environments (Gilmore et al. 2023).

In ageing governance, the commercial determinants bottleneck operates through at least four channels (Lacy-Nichols et al. 2023).

(1) Commodification and stratification of care: when long-term care is marketised, access and quality can become increasingly stratified. Those with resources purchase continuity and support; those without resources encounter fragmented services, delayed access, and greater reliance on unpaid care. The result is "longevity stratification": not only differences in lifespan, but differences in the distribution of disability, dependency, and dignity. Under such conditions, "active ageing" risks becoming a premium good rather than a shared ethical commitment.
(2) Profit-biased innovation: innovation tends to follow profitability, not equity. This is not a moral indictment; it is a structural observation. Technologies that generate recurring revenue (devices, subscriptions, pharmaceuticals, proprietary platforms) can attract more investment than interventions that build public goods (housing adaptation, social connection infrastructure, caregiver support, community-based prevention). The epistemic–existential paradox emerges when societies equate the expansion of market-driven innovation with progress, while underinvesting in capability infrastructures that would deliver well-being at scale.
(3) Regulatory capture and policy friction: commercial influence can shape what is regulated, how it is regulated, and what counts as "evidence" in policy (Petticrew et al. 2023). In ageing and health, this can distort public priorities, shifting attention toward downstream consumption and away from upstream structural determinants. The effect is not only economic; it is epistemic. It shapes what is seen as feasible and what is rendered invisible.
(4) Narrative capture: responsibilisation as market compatibility: market logics align neatly with a moral narrative that locates responsibility in individuals. If health becomes an individual project, then the appropriate response is consumer choice: buy the right product, adopt the right routine, subscribe to the right service. The ethical problem is that this narrative can legitimise structural neglect. It turns a capability deficit into a personal inadequacy and converts the malaise state's governance failures into a demand for individual resilience.

A potential objection is that markets also disseminate innovations rapidly and increase access through scale. This is sometimes true. But the relevant question for a bioethics of healthy ageing is not whether markets can deliver innovations; it is whether the governance of markets and technologies aligns with the equity commitments of the Decade. The WHO equity framework makes clear that without upstream action, health gaps persist and deepen (World Health Organization 2025b). Commercial determinants therefore must be treated as a predictable source of translation failure unless constrained by governance oriented to equity.

3.4. Datafication and epistemic asymmetry: when digitalisation amplifies dependency

The transmodern context intensifies translation failure not only through marketisation but through datafication: the conversion of life processes into data streams for monitoring, prediction, and governance. In principle, datafication can support healthy ageing by enabling early detection, continuity, and personalised support (Biese et al. 2022). In practice, without equity-oriented governance, it can amplify two forms of asymmetry: access asymmetry and epistemic asymmetry.

Access asymmetry refers to the uneven distribution of digital tools, connectivity, skills, and supportive environments (Ge et al. 2025). Digital health interventions can widen capability gaps if they become prerequisites for timely care or for navigating systems (Mistry et al. 2022). Older persons with limited digital access or skills may experience intensified administrative load, precisely at a life stage when functional decline makes such burdens more consequential (Choi et al. 2024).

Epistemic asymmetry refers to the unequal distribution of interpretive power. Datafied systems can position older persons as monitored objects rather than as interpretive agents. Decision-making may shift toward opaque analytics, organisational protocols, and platform logics. Even when systems claim to "empower" users, they can increase dependence by making autonomy conditional on compliance with data-driven norms.

These dynamics intersect with the malaise state in a specific way: when welfare institutions are configured as scarcity managers, digitalisation is often deployed as an efficiency tool rather than as an equity tool. The result can be "digital triage": automated filtering, delayed access, and the displacement of human interpretation by procedural classification. Under such conditions, datafication does not solve the epistemic–existential paradox; it can become one of its accelerators.

The ethical stakes are amplified because healthy ageing, as functional ability enabling well-being, requires not only services but meaningful autonomy. Autonomy is not satisfied by the formal availability of data. It requires the capacity to interpret, decide, and act under conditions of trust and support. When datafication is governed through commercial determinants, additional concerns arise: proprietary ecosystems, lock-in, surveillance incentives, and the conversion of ageing-related vulnerability into revenue streams. These concerns are not peripheral; they are translation mechanisms. They determine whether knowledge infrastructures become capability infrastructures or dependency infrastructures.

A further counterargument is that datafication is inevitable and that resisting it is impractical. The argument here does not require resistance to technology. It requires governance criteria aligned with the Decade: digital systems should be evaluated by whether they expand functional ability under equity constraints, reduce administrative load, preserve interpretive agency, and avoid transferring risk to those least able to bear it (World Health Organization 2022). Technology is not the causal driver; the governance regime is.

3.5. Synthesis: the epistemic–existential paradox as a predictable outcome of malaise-state governance

The preceding analysis allows a compact synthesis. The epistemic–existential paradox is not an accidental mismatch between scientific promise and social reality. It is a predictable outcome of malaise-state governance under transmodern conditions.

- The *malaise state* produces downstream bias, administrative load, risk transfer, and routine triage (Koutsogeorgopoulou & Morgavi 2025).
- The social determinants bottleneck stratifies functional ability across the life course, making "active ageing" unequal by design unless enabling environments and protections are equitably distributed (World Health Organization 2025b).
- The commercial determinants bottleneck biases innovation, care provision, and narratives toward profit-compatible pathways that can conflict with equity and dignity (World Health Organization Regional Office for Europe 2024).
- Datafication, when deployed as efficiency governance under scarcity, intensifies access and epistemic asymmetries, converting empowerment rhetoric into new forms of dependence.

Taken together, these mechanisms explain why knowledge proliferation can coexist with equity failure. They also clarify the bioethical stakes of the UN Decade of Healthy Ageing. The Decade's ambition cannot be realised by adding information campaigns, lifestyle prescriptions, or isolated innovations to a malaise-state infrastructure. It requires a governance correction: converting knowledge and technology into shared capability infrastructures, and judging "active ageing" policies by whether they preserve functional ability and dignity under conditions of health equity (World Health Organization 2020; World Health Organization 2022; World Health Organization 2025b).

This conclusion also reframes the welfare-state debate. The question is not whether welfare should be larger or smaller in the abstract. The question is whether welfare institutions are designed to expand capabilities and equity, or whether they have drifted into scarcity management that normalises dependency while invoking empowerment as rhetoric. If the latter holds, the ethical promise of healthy ageing becomes a performative contradiction: societies publicly commit to well-being in older age while maintaining institutional conditions that reliably prevent it.

Section 4 will extend this diagnosis to the global justice dimension of ageing "at two speeds" and will articulate policy-relevant ethical commitments for the Decade: commitments that confront structural determinants rather than displacing responsibility onto individuals, and that treat dignified longevity as a capability-dependent good owed to persons as a matter of justice.

4. Global Justice and the UN Decade: Ageing at Two Speeds, Ethical Commitments, and Policy Implications

4.1. Ageing at two speeds: demographic divergence and moral asymmetry

The ethical stakes of the UN Decade of Healthy Ageing cannot be adequately captured by a domestic welfare-state lens. Population ageing is global, but it is not globally symmetrical. Recent UN projections continue to document profound divergence in age structures, dependency ratios, and the timing and pace of demographic transition across regions (United Nations, Department of Economic and Social Affairs, Population Division 2024). In high-income settings, policy debates often presuppose that most people will reach older age, and the question becomes how to finance long-term care, manage

multimorbidity, and sustain pensions. In many low-income settings, by contrast, a significant proportion of the population faces avoidable early mortality and truncated life courses, rendering the "problem" of very old age ethically downstream of the more basic problem of survival under conditions of deprivation (World Bank 2023).

This divergence yields an uncomfortable moral asymmetry. Healthy ageing is framed, rightly, as the maintenance of functional ability enabling well-being (World Health Organization 2020). Yet functional ability presupposes a life course that is sufficiently protected for capability formation to occur. When large populations do not reliably reach older age, or reach it after a lifetime of structural disadvantage, the distribution of "ageing itself" becomes ethically stratified. The Decade's normative horizon therefore demands a justice-sensitive interpretation: healthy ageing cannot be a privileged achievement of already-protected populations; it must be an equity-oriented commitment to expanding capabilities across unequal social worlds (World Health Organization 2022; World Health Organization 2025b; Rawls 1971; Daniels 2008; Whitehead 1992).

4.2. The malaise state in a global frame: the epistemic–existential paradox as a planetary translation failure

Sections 2 and 3 argued that the epistemic–existential paradox emerges when biomedical knowledge and technoscientific capacity proliferate without being translated into shared capability infrastructures. That translation failure is not merely national; it is planetary.

At the global level, knowledge and technological infrastructures are heavily concentrated, while well-being and survival remain sharply unequal. The WHO's 2025 synthesis on social determinants of health equity emphasises that avoidable health gaps are driven by upstream, non-medical causes and can shorten lives by decades (World Health Organization 2025b). This directly implicates global political economy: trade regimes, labour conditions, environmental exposures, debt and fiscal constraints, migration patterns, and the uneven distribution of health-system capacity. The malaise state, in its broader sense, is thus not only a "welfare drift" phenomenon within affluent societies. It is also a regime of global governance in which structural determinants and commercial determinants organise predictable inequities in life chances (Farmer 2004).

The ethical consequence is that "active ageing" rhetoric can function as a double displacement. In high-income contexts, it can displace institutional responsibility onto individuals and families, normalising scarcity governance while invoking empowerment. In low-income contexts, it can displace global responsibility by treating healthy ageing as a technical agenda rather than as a justice agenda, thereby obscuring the upstream conditions that prevent capability formation in the first place. The Decade risks becoming a performative contradiction if it is interpreted as a health-sector programme instead of a capability- and equity-oriented transformation consistent with SDG commitments (World Health Organization 2022).

4.3. Ethical commitments for the UN Decade: from rhetoric to capability governance

If the Decade is to be ethically coherent, it must be governed through commitments that directly target translation failure. The following six commitments operationalise that requirement without converting this paper into a policy blueprint. They are intended as bioethical criteria for evaluating whether "active ageing" initiatives are aligned with healthy ageing as functional ability under conditions of equity.

Commitment 1: equity-first functional ability.

Healthy ageing must be assessed in capability terms, not in aggregate averages. A policy cannot be deemed successful if it improves outcomes for already-advantaged groups while leaving disadvantaged groups with the highest administrative load, the least continuity of care, and the weakest environments. Equity is not a secondary "distribution question" after innovation; it is the ethical condition of legitimacy for the Decade (World Health Organization 2025b; Carroll et al. 2022).

Commitment 2: upstream rebalancing toward enabling environments.

A downstream, service-delivery orientation cannot deliver functional ability at scale. The Decade's ethical logic requires rebalancing toward the upstream conditions that preserve intrinsic capacity and reduce avoidable dependency: housing, walkable and safe environments, social connection infrastructures, preventive public health, and continuity-oriented primary care (World Health Organization 2020). This is not idealism; it is the consequence of adopting functional ability as the standard.

Commitment 3: administrative justice as health equity.

Administrative complexity is not merely inconvenient; it is ethically distributive (Herd and Moynihan 2018; Health Affairs 2020). Reducing administrative load, simplifying entitlements, and improving procedural transparency are equity interventions because they expand real access for those with fewer resources and lower institutional fluency. Under malaise-state governance, "waiting" and "navigation burdens" become silent rationing mechanisms (Kervin et al. 2025). The Decade's equity commitments require that these burdens be treated as structural harms, not as user failures (World Health Organization 2025b).

Commitment 4: care justice and the ethics of risk transfer.

Where scarcity governance transfers care burdens to families, it redistributes vulnerability rather than mitigating it. The Decade must treat long-term care as a justice domain: recognising caregiving labour, preventing exploitative reliance on unpaid care, and sustaining dignified autonomy for those who need assistance (Costa-Font et al. 2021). Otherwise, "active ageing" becomes ethically incoherent: autonomy rhetoric masking dependency produced by structural neglect (World Health Organization 2022).

Commitment 5: governance of commercial determinants in ageing policy.

Commercial determinants shape exposures, consumption environments, and policy options in ways that can predictably conflict with equity goals (Friel et al. 2023). Ageing governance must therefore include explicit criteria for constraining misaligned incentives, preventing care commodification from becoming dignity stratification, and ensuring that innovation pathways are not systematically biased away from public goods (World Health Organization Regional Office for Europe 2024). This is not anti-market doctrine; it is the ethical demand that markets be governed to serve healthy ageing rather than to monetise vulnerability.

Commitment 6: datafication with agency (preventing epistemic dependency).

Digital health and data infrastructures must be evaluated by whether they expand functional ability and interpretive agency under equity constraints. Systems that automate triage, increase opacity, or make access conditional on digital competence can deepen epistemic asymmetry and intensify dependency. A Decade-aligned digital agenda requires accessibility, transparency, proportionality, and support for meaningful autonomy rather than mere monitoring (World Health Organization 2025b; The Lancet Digital Health 2023).

Taken together, these commitments clarify why healthy ageing without health equity is not simply "suboptimal" but ethically inconsistent. If healthy ageing is functional ability enabling well-being, and if functional ability is co-produced by environments and institutions, then equity is not a distributive afterthought. It is part of what healthy ageing means.

4.4. A Decade-alignment evaluation checklist

To keep the argument operational, the commitments can be expressed as an evaluative checklist that can be applied to programmes, reforms, or institutional designs. A policy is Decade-aligned only if it can answer "yes" to most of the following:

1. Equity impact: does the intervention measurably reduce capability gaps (not only improve averages), especially for disadvantaged groups? (World Health Organization 2025b)
2. Upstream orientation: does it invest in enabling environments and continuity rather than primarily funding late-stage service throughput? (World Health Organization 2020)
3. Administrative load: does it reduce procedural friction, improve transparency, and decrease navigation burdens for users and families? (World Health Organization 2025b)
4. Risk transfer: does it avoid silently transferring costs and care labour to families without support, recognition, and protection? (World Health Organization 2022)
5. Commercial determinants: does it explicitly address incentive misalignment and prevent commodification from becoming dignity stratification? (World Health Organization Regional Office for Europe 2024)

6. Digital equity: are digital components optional, supported, and accessible, or do they become gatekeepers that widen inequities? (World Health Organization 2025b)
7. Agency and interpretability: does it preserve older persons' interpretive agency, or does it increase epistemic dependence on opaque systems?
8. Life-course coherence: does it acknowledge cumulative disadvantage and design protections accordingly, rather than moralising "active ageing" as individual responsibility? (World Health Organization 2020; World Health Organization 2025b)

This checklist does not replace empirical evaluation. It functions as a bioethical audit tool: it converts the Decade's normative horizon into criteria that can expose performative contradictions where empowerment rhetoric coexists with scarcity governance.

4.5. Closing the argument: dignified longevity as a capability-dependent good

The central claim of this paper can now be stated with precision. The UN Decade of Healthy Ageing sets a normative horizon that is incompatible with a malaise-state trajectory in which welfare institutions drift toward scarcity management, risk transfer, and routine triage. Under those conditions, knowledge proliferation does not translate into well-being; it translates into stratified capability sets. The epistemic–existential paradox is therefore not a mystery. It is a predictable outcome of misaligned governance.

The Decade's ethical promise can be preserved only if "active ageing" is reconstructed as dignified longevity under conditions of health equity, judged by whether institutions and environments expand functional ability for those least advantaged. This reconstruction also prevents two symmetrical errors: nostalgia for welfare without diagnosis, and individualised "active ageing" without justice. In capability terms, the task is not to demand more activity from older persons. It is to design the conditions under which older persons can sustain agency, relationships, and meaningful autonomy as a matter of justice, consistent with the SDG-aligned commitments that frame the Decade (World Health Organization 2022).

The next section will consolidate these implications into a concise conclusion: summarising the article's contributions, acknowledging limits, and outlining an agenda for bioethical work on ageing governance that treats equity not as an aspiration but as the condition of ethical legitimacy.

5. Conclusion

This article has argued that the central bioethical fault-line in contemporary ageing governance is not simply between "more" versus "less" welfare, nor between biomedical versus social models of ageing (Engel 1977). It lies between two regimes of governance: passive-assisted ageing, in which institutions primarily manage decline through downstream interventions under scarcity conditions, and active ageing reconstructed as dignified longevity under conditions of health equity, consistent with the WHO understanding of healthy ageing as the maintenance of functional ability enabling well-being

(World Health Organization 2020). When this normative yardstick is adopted, the ethical question shifts from the volume of services delivered to the conversion conditions through which societies enable or disable older persons' real freedoms across the life course.

To make sense of why knowledge-rich societies can nevertheless become well-being-poor ageing societies, the paper proposed a diagnostic pair: the malaise state and the epistemic–existential paradox. The malaise state names a structural syndrome of welfare drift in which protective institutions increasingly operate as scarcity managers: rationing becomes routine, administrative load expands, and risk is transferred outward to individuals and families. Under such conditions, ageing governance predictably defaults to downstream triage and fragmented assistance, rather than to capability preservation and enabling environments. The epistemic–existential paradox formalises the translation failure that follows: the proliferation of biomedical knowledge, technological capacity, and digital infrastructures does not reliably translate into shared well-being because it is mediated by institutional design, political economy, and the uneven distribution of power, resources, and trust. In WHO's most recent synthesis, health inequities are driven by upstream social determinants and can shorten lives by decades, indicating that technoscientific progress alone cannot deliver equity without structural transformation (World Health Organization 2025b).

Section 3 specified three mechanisms through which translation failure becomes predictable rather than accidental. First, the social determinants bottleneck stratifies functional ability: environments, income security, education, and institutional navigability shape life-course trajectories of capacity and vulnerability (World Health Organization 2025b). Second, the commercial determinants bottleneck biases innovation, service provision, and narratives toward profit-compatible pathways that often conflict with equity, including the commodification and stratification of care (World Health Organization Regional Office for Europe 2024). Third, datafication can amplify both access asymmetry and epistemic asymmetry when digital systems are deployed as efficiency instruments within scarcity governance, making empowerment conditional on digital competence and compliance rather than on meaningful autonomy.

Section 4 extended this diagnosis to the global frame. Ageing is not a uniform human condition but an unequally distributed life-course horizon. UN projections underscore divergent demographic trajectories across regions (United Nations, Department of Economic and Social Affairs, Population Division 2024), while World Bank indicators document persistent gaps in life expectancy at birth, including low-income contexts where early mortality remains a defining injustice (World Bank 2023). The Decade's SDG-aligned commitment to "leaving no one behind" therefore cannot be interpreted as a narrow ageing-services agenda; it must be interpreted as a justice project in which healthy ageing is inseparable from equity governance (World Health Organization 2022). In this context, the article's title is not rhetorical: healthy ageing without health equity is conceptually incoherent and ethically unstable. It risks becoming a language of dignified longevity for the protected, while the structural conditions of capability formation remain unequal within and between societies.

The article has three main contributions to bioethical inquiry. First, it offers a conceptual distinction between passive-assisted ageing and equity-grounded active ageing that avoids both nostalgia for welfare institutions and moralised responsibilisation of individuals. Second, it provides a diagnostic framework that links lived contradictions

of later life (dependency, waiting, administrative friction, loss of agency) to structural mechanisms (scarcity governance, determinants bottlenecks, datafication) without reducing the problem to either personal choice or technological inevitability. Third, it proposes action-guiding ethical criteria for evaluating policies under the UN Decade: equity-first functional ability, upstream rebalancing toward enabling environments, administrative justice, care justice, governance of commercial determinants, and datafication with agency (World Health Organization 2020; World Health Organization 2022; World Health Organization 2025b; World Health Organization Regional Office for Europe 2024).

Several limits should be acknowledged. The argument is conceptual and normative; it does not claim to provide a comparative empirical evaluation of specific national systems or to quantify the relative causal weight of each mechanism. Welfare institutions vary significantly across contexts, and the pathways to malaise-state drift will differ according to fiscal architecture, political culture, demographic timing, and the organisation of health and long-term care. Furthermore, while the paper critiques capitalism through the lens of commercial determinants and incentive misalignment, it does not offer a comprehensive political-economic theory of global inequality. These limits are appropriate to the paper's aim: to supply bioethics with a coherent framework for analysing why the Decade's normative commitments are often undermined by predictable translation failures, and to clarify what counts as ethical alignment with healthy ageing.

Future work can build on this framework in two directions. Empirically, comparative research can operationalise the "Decade-alignment" checklist developed in Section 4 to test whether specific reforms reduce administrative load, preserve functional ability, and narrow equity gaps. Normatively, bioethical inquiry can further articulate the responsibilities of states, commercial actors, and international institutions in governing determinants that structure life-course capability formation, including the design of digital infrastructures that either expand or erode interpretive agency.

If the UN Decade of Healthy Ageing is to be more than a rhetorical horizon, it must be judged by its capacity to convert knowledge into equity, and innovation into shared capability infrastructures. Active ageing, in this paper's sense, is not a demand placed on older persons. It is an obligation placed on institutions: to enable dignified longevity by preserving functional ability under conditions of health equity, within and across the unequal worlds in which humans grow old.

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